NEW HAMPSHIRE
MEDICAID BULLETIN

This publication is an important link between your office and the New Hampshire Medicaid (Title XIX) Program, and should be read by all medical and administrative staff within your organization. **Please be sure to download the entire contents of this bulletin** by going to the NH Department of Health and Human Services website at: http://www.dhhs.nh.gov/DHHS/MEDICAIDPROGRAM/LIBRARY/Newsletter/medicaid-bulletin.htm or the EDS provider website at: www.nhmedicaid.com. We recommend that all issues of the newsletter be maintained with your Medicaid Billing Manual to be used as a handy reference of provider requirements related to NH Medicaid (Title XIX) policy and billing matters.

TITLE XIX BULLETIN	VOLUME XII	ISSUE VI	MARCH 2007

* * * TABLE OF CONTENTS * * *

*** <u>PLEASE NOTE</u>: There were no Medicaid bulletins released in September or December, 2006.**

APPENDIX

- <u>Form</u> 957X - Override Request
- <u>Form</u> 112- Consent to Sterilization Form
- Attachment to the NPI Notice

*** ALL PROVIDERS ***

Is there an article you would like to see in this publication? If so, please send your suggestions, on your company letterhead, to: EDS, 7 Eagle Square, Concord, NH 03301, attn: Michelle Dodge. Our staff will research your suggestion for the article, and possibly publish your requested article.

Thanks for helping us help you!

EDS HOLIDAYS

EDS holidays for the remainder of the 2007 calendar year are:

Memorial Day	Monday	May 28, 2007
Independence Day	Wednesday	July 4, 2007
Labor Day	Monday	September 3, 2007
Veteran's Day	Monday	November 12, 2007
Thanksgiving Day**	Thursday	November 22, 2007
Day after Thanksgiving	Friday	November 23, 2007
Christmas Day	Tuesday	December 25, 2007

Please note:

****** Electronic claim submissions must be received at EDS by 5:00 p.m. on the Tuesday prior to the holiday in order to guarantee they make that weekend's financial cycle.

MEDICAID FRAUD UNIT- CIVIL RECOVERY

The Medicaid Fraud Unit of the New Hampshire (NH) Attorney General's Office has statewide responsibility to investigate cases involving the suspected improper billing of NH Medicaid covered services. This unit, staffed by attorneys, investigators, and analysts, also investigates concerns of waste, fraud and abuse in the state administration of the NH Medicaid Program.

Recently, the Medicaid Fraud Unit of the NH Attorney General's Office (the Unit) settled a case for $45,000 against a home health care provider for allegedly overcharging Medicaid for certain child and family health care support services. The audit focused on the quantity and type of services provided and related record-keeping requirements. The Unit found that in some cases, Medicaid was improperly charged for what appeared to be ordinary child care services.

Also, the Unit recently concluded a case that involved settlements totaling almost $43,000 against three providers related to services provided by a clinical social worker under contract with a school administrative unit (SAU) and an area mental health agency. The SAU was required to reimburse Medicaid $24,300 for allowing the clinical social worker to bill Medicaid directly for certain school based services. Under the law, the SAU was required to bill those services using its own provider number. In separate settlements resulting from the same investigation, the clinical social worker and area agency agreed to pay a total of $18,600 based on evidence that group therapy services were charged under an individual therapy procedure code.

For more information, or to report concerns regarding Medicaid waste, fraud, abuse, or improper billing, please contact the Medicaid Fraud Unit by phone at (603) 271-1246, by e-mail at mfcuinfo@doj.state.nh.us, or by writing to: Medicaid Fraud Unit, 33 Capitol Street, Concord, NH 03301. Communications are treated as confidential.

TIMELY FILING OF CLAIMS

All claims must be submitted to EDS within one year of the date of service. Claims that are beyond the one-year filing limit, that have previously been submitted and denied, must be resubmitted on paper, along with Form 957x, "Override Request" and a copy of the remittance advice showing the denial within one year from the date of service. A copy of Form 957x may be found at the end of this bulletin, or may be downloaded from the provider web site, at: www.nhmedicaid.com. This resubmission must be received within 15 months of the date of service. Please refer to the June 2002 Edition of the NH Medicaid Bulletin for detailed information and process requirements.

OPTICAL CHARACTER RECOGNITION (OCR) PAPER CLAIMS SCANNING PROCESS

We are reminding all providers that the current paper billing guidelines went into effect on July 1, 2003. In March 2003, providers received an important notice regarding these changes; workshops were held in April and May of 2003, and June and October of 2004, as well. If you did not receive this information please go to our provider web site www.nhmedicaid.com to obtain a copy of the information that was provided. If you have questions regarding the paper billing guidelines, please contact the Communications Unit at 1-800-423-8303 (NH & VT only) or (603) 224-1747.

To avoid a delay in your payment because of claims returned as unable to be processed, please remember the following:

- Include the other insurance **4 digit** carrier code **(do not include carrier name)** in the appropriate area on the claim (if applicable)
    - CMS 1500 - box 9d
    - UB-92 - box 50
    - ADA 1999, version 2000 - box 36
- Please indicate the other insurance payment on the claim form (if applicable)
    - CMS 1500 - box 29
    - UB-92 - box 54
    - ADA 1999, Version 2000: total fee - payment by other plan = carrier pays (box 60)
- Other insurance denial reason(s) should be indicated on claim; please enter information in correct box (if applicable)
    - CMS 1500 - box 19
    - UB-92 - box 84
    - ADA 1999, version 2000 - box 60

Remember, effective July 1, 2003, paper crossovers were required to be attached to a claim form. The claim form must:

- Match the claim type of the EOMB; and
- Outpatient claims can not have a date span.
    - If crossovers span more than a day on outpatient, please enter the "from" and "to" date as the same in form locator 6; and
    - If the services span across more than one claim form, roll services up to one claim, carefully adding the units and dollars.

What Will Cause My Claim to be Returned as Unprocessed Under the OCR Rules?
As of July 1, 2003, **paper claims** began to be imaged and then went through the OCR process as the first steps in claim processing and payment. You can **prevent delays** to your anticipated payment date by following these tips:

- **DO NOT submit laser printed red** claim forms;
- **DO NOT** use **highlighters** on any claim form(s) or adjustment(s). Highlighted areas show up as black lines, just as they do when highlighted forms are photocopied or faxed;
- **DO submit only Red UB92 or CMS claim forms.** Faxed claims or claim copies will not be accepted;
- **DO** use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing;
- **DO** ensure that your printers are properly aligned, and that your print is dark and legible, if you are using a printer to create claim forms;
- **DO** use only **black ink** on **ALL** claims or adjustments that you submit to EDS. The **EDS imaging/OCR system reads only black ink**;
- **DO** make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s); and
- **DO** call the Communications Unit at 1-800-423-8303 (NH and VT only) or (603) 224-1747 if you have questions.

EDS WEB SITE

Have you visited our provider web site, www.nhmedicaid.com? This is a great tool for obtaining the latest provider billing information, researching covered procedure codes for your provider type, or for just sending us an e-mail with your question. You should receive a response to your e-mail within 1-2 business days.

THIRD PARTY LIABILITY CARRIER CODE ADDITIONS/CHANGES

The following third party liability carrier codes have been added since the June 2006 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0767	CONSECO HEALTH INSURANCE CO, PO Box 66904, Chicago, IL 60666-0904
0768	DELTA DENTAL USA/NORTH PACIFIC GROUP INC., Dentist Benefits Corp., 601 S W 2nd Ave, Portland, OR 97204
0769	NHP GROUP LIMITED BENEFIT CLAIMS, PO Box 8006, Dublin, OH 43016
0770	CCMSI MIDLAND, LLC, PO Box 1430, Danville, IL 61834-1430
0771	CHEROKEE INSURANCE, PO Box 159, Warren, MI, 48090
0772	COLUMBIAN MUTUAL, PO Box 1527, Latham, NY 12110
0773	PRIME THERAPEUTICS, PO Box 64812, St. Paul, MN 55164
0774	TWENTYFIRST HEALTH AND BENEFITS, PO Box 5037, Cherry, NJ 08034
0775	EVANGELICO, 3103 Emmorton Rd., Abington, MD 21009
0776	PATRIOT HEALTHCARE, PO Box 2000, Exeter, NH 03833
0777	DELTA DENTAL OF OREGON-ODS, 601 Southwest 2nd Ave., Portland, OR 97204
0778	SCOTT & WHITE HEALTH PLAN, 2401 S 31st St., Temple, TX 76508
0779	ACEC LIFE/HEALTH TRUST HEALTHPLAN, PO Box 5190, Tampa, FL 33675
0780	GATEWAY HEALTH PLAN, PO Box 11560, Albany, NY 12211-0560
0781	CELTIC INDIVIDUAL HEALTH, PO BOX 33839, Indianapolis, IN 46203-0839
0782	INNONVIANT, PO BOX 8082, Wausau, WI 54402

The following third party liability carrier codes have been re-activated (taken out of archives) since the June 2006 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0485	INSURANCE DESIGN ADMIN, PO Box 875, Oakland, NJ 07436
0581	ASSURANT EMPLOYEE BENEFITS, PO Box 2940, Clinton, IA 52733
0746	BENEFIT PLAN MANAGEMENT, PO Box 536, Rockland, MA 02370

The following third party liability carrier codes have been archived since the June 2006 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0702	STAR HRG, PO Box 55270, Phoenix, AZ 85078-5270 (Please use carrier code 0385 instead).
0708	MAILHANDLERS PRESCRIPTION DRUG CLAIMS, PO Box 23824, Tuscon, AZ 85724
0725	AMERICAN HEALTHCARE ALLIANCE

The following third party liability carrier codes have had changes since the June 2006 edition of the NH Medicaid Bulletin:

CODE	COMPANY NAME
0017	BC/BS OF MASSACHUSETTS, PO Box 986020, Boston, MA 02298 (address change only)
0056	AP BC/BS OF MASSACHUSETTS, PO Box 986020, Boston, MA 02298 (address change only)
0077	NORTH AMERICAN ADMINISTRATORS, PO Box 853921, Richardson, TX 75085-3921
0246	AMERICAN ADMINISTRATIVE GROUP (was Gallagher Benefit Admin), PO Box 93670, Lubbock, TX 79493-3670
0347	OXFORD, PO Box 7082, Bridgeport, CT 06601-7082 (address change only)
0349	PACIFIC SOURCE, PO Box 7068, Eugene, OR 97401-0068 (address change only)
0426	BC/BS OF CA DENTAL, PO Box 9201, Oxnard, CA 93031-9201 (address change only)
0630	BENESIGHT, PO Box 360, Pueblo, CO 81002 (address change only)
0773	PRIME THERAPEUTICS, PO Box 64812, St. Paul, MN 55164

TELEPHONE INQUIRIES- IMPROVING PROCESSING TIME

In an effort to respond to provider inquiries faster, and reduce call times, we are reminding our providers that the following required information should be immediately available when providers call the Communications Unit:

- Your eight (8) digit NH Title XIX provider number. If you do not have this number, you may obtain it from your billing department. **Please note**: The provider number is **not** the same as the federal tax ID number.

- The NH Title XIX recipient's eleven (11) digit **NH Medicaid ID (MID)** number. If you do not have a recipient MID, you will need to provide the recipient's **last name, first name, and either a date of birth or social security number**. **Please note**: Name searches may only be done if the recipient, or guardian, has given a reasonable indication that the recipient is a NH Title XIX recipient.

- When checking on claim status, you will need the **"from and through"** dates that were billed on the claim form, as well as the **total billed amount** that was indicated on the claim form.

Please be advised that a call made to the Communications Unit that is placed on hold by the caller will be discontinued, because the telephone lines must be kept clear for other callers. Please make the call only when you have the required information on hand and the time to complete the call.

Other contact numbers for obtaining information regarding provision of NH Title XIX covered medical services are as follows:

- Prescription/NDC inquiries by **providers** should be directed to:
  FIRST HEALTH
  Provider Services: 1-866-664-4511
  Prior Authorizations: 1-866-675-7755

NH Title XIX **recipients** who have questions about their NH Title XIX covered services, should be directed to:

- NH Title XIX Client Services:
  In state: 1-800-852-3345, extension 4344
  Out of state: 1-603- 271-4344

If you have questions concerning the contents of this article, please call the Communications Unit at 1-800-423-8303 (NH & VT only) or (603) 224-1747.

RECEIPT OF YOUR 997 FUNCTIONAL ACKNOWLEDGEMENT

Have you Confirmed Receipt of your 997 Functional Acknowledgement? The 997 Functional Acknowledgement is a HIPAA compliant transaction that electronically informs you that your electronic claims files have reached EDS. It is important that providers who submit claims electronically, confirm receipt of an accepted 997 Functional Acknowledgment. Confirmation of an accepted 997 Functional Acknowledgement ensures that your 837 claim file(s) have been received by EDS. If you use EDS' Provider Electronic Solutions software, follow the steps below to retrieve your 997 Functional Acknowledgement, **once your claims have been transmitted**.

- On the main menu select "Communications";
- Select "Submission";
- When "Batch Submission" window appears, highlight "Functional Acknowledgment" and "Claim Accept/Reject";
- Click on the submit button;
- When you receive the message "Submission Successful", close the window;
- Click on "Communications", then "View Accept/Reject Claim report - Functional Acknowledgement";
- Select from the list the file that you want to view by highlighting the file in the top portion of the screen.

If you transmit your claims by using vendor software, you must download your 997 Functional Acknowledgment from the NH Medicaid Provider web site at: www.nhmedicaid.com.

- From the Home Page click on "Transaction Services", then "Production Login";
- Enter your Trading Partner Agreement (TPA) number in the "User ID" field, then enter your password and click "Log In";
- Select "Download Files";
- You may then view and/or download your report(s);
- These reports are available for 90 days before being archived.

The value of **"A"** in segments **AK5 & AK9** confirms your submission was successful. The value of **"R"** in segments **AK5 & AK9** indicates your submission was rejected. If you receive a rejected 997 Functional Acknowledgment, you will need to identify and correct the errors prior to resubmission of your claim files(s). Once your claim file(s) are resubmitted, you may follow the above steps for retrieval of the 997 Functional Acknowledgement and Claim Accept Reject report(s).

If you have questions regarding the contents of this article, please call the Communications Unit at 1-800-423-8303 (NH & VT only) or (603) 224-1747.

SUBMITTING ELECTRONIC ADJUSTMENTS (REPLACEMENTS) AND VOIDS

Providers have the option to adjust/void claims electronically instead of submitting paper Adjustment/Recoupment Request forms to EDS. Below are some tips to assist in the process:

- Providers submitting electronic claim adjustment/voids using EDS' Provider Electronic Solutions software for 837 professional claims and dental claims, change the claim frequency to "7" for a Replacement claim (Adjustment) or "8" for a Void, and then enter the original Transaction Control Nubmer (TCN) in the "Original Claim #" field located on the Header 1 tab;

- For 837 Institutional Claims, change the last digit of the TOB (frequency code) to equal "7" for a Replacement claim (Adjustment) or "8" for a Void, and then enter the original Transaction Control Nubmer (TCN) in the "Original Claim #" field located on the Header 1 tab;

- Providers should make the necessary changes, save and submit the claim;

- Only paid claims can be adjusted or voided;

- For providers submitting Professional and Dental electronic adjustments using vendor software, the Claim Frequency Type Code is located in Loop 2300, CLM05-3;

- For providers submitting Institutional and Nursing Home electronic claims adjustments using vendor software, the Claim Frequency Type Code field is located in Loop 2300, CLM 05 segment;

- Enter the TCN in Loop 2300 for all claim types, REF02 segment including the Reference Identification Qualifier (F8) for the claim to be replaced/voided;

- Claims submitted with a frequency of "7" for a "Replacement" claim will appear on your remittance advice as a recoupment of the original TCN and a new payment/denial with a new TCN as this process is technically a recoup/rebill all in one step.

  Note: Failure to fill in these fields when the Claim Frequency Type Code field shows a "7" or "8", or the TOB ends in a 7 or 8, will result in a denial with the Explanation of Benefits (EOB) 537- "Electronic adjustment is invalid", and no replacement/void will occur.

For timely filing:

a. Adjustment/Replacement- **DO NOT** perform an adjustment of a claim with a date of service greater than one year. Since adjustments are subject to timely filing guidelines, your original payment will be recouped, and your adjustment will fail for Explanation of Benefits (EOB) 076- CLAIM DENIED PAST FILING LIMIT. These adjustments must be sent on paper.
b. Void or Cancel- Can be performed for any paid claims.

Submitting electronic adjustments (replacements)/voids will allow providers to receive proper payment of claims faster than submitting paper forms. If you have questions regarding the contents of this article, please call the Communications Unit at 1-800-423-8303 (NH & VT only) or (603) 224-1747.

IMPLEMENTATION OF THE NPI (NATIONAL PROVIDER IDENTIFIER)

The NH Department of Health and Human Services (DHHS) and Electronic Data Systems (EDS) are working diligently to address the need for compliance with the implementation of the National Provider Identifier on May 23, 2007.

DHHS and EDS acknowledge that not all providers may be ready by the May 23, 2007 compliance date and, despite all efforts undertaken, it is likely that DHHS' claims processing system run by EDS may not be ready to completely cut-over to processing with the National Provider Identifier (NPI) by the compliance date. Given the significance of this transition, we must execute an interim **Contingency Plan** to ensure that providers can continue, without interruption, to submit claims and other electronic transactions and that the EDS run claims processing system is able to process those transactions and issue the appropriate response to providers.

The Contingency Plan **requires all providers and/or their agents** submitting transactions to EDS to do the following in order to prevent an interruption in services:

1. **All Providers must continue to submit their NH Title XIX (Healthy Kids-Gold/Medicaid) Provider Identification number on electronically submitted claims in order for claims to be paid through NH Title XIX past May 23, 2007. This Identifier is the eight-digit number, assigned to providers by EDS.**

2. **All Providers submitting paper claim forms must continue to use the current CMS 1500 and UB92 Claim forms and defer switching to NPI-compliant CMS 1500(08/05) and UB04 Claim forms until receiving further instructions from EDS.**

3. **All Providers must submit their National Provider Identifier(s) and corresponding Taxonomy to EDS as soon as possible. The NPI is a 10-digit number, acquired by providers from the national enumerator.**

More specific information is provided below and in the Attachment to this notice. DHHS and EDS request that all Providers and/or their agents take the appropriate action to address each of the Contingency Plan requirements and immediately review the details that follow with your billing agent, IT department, clearinghouse and/or software vendor to ensure the continued inclusion of the

NH Title XIX (Healthy Kids-Gold/Medicaid) Provider ID on all submitted claims and electronic transactions.

The primary objectives of this contingency period are to ensure that claims and other electronic transactions submitted by providers are processed without interruption, and to ensure that providers receive the appropriate claims reimbursement and responses to their electronic inquiries. DHHS and EDS appreciate providers' efforts in working with us to maintain uninterrupted service delivery and claims processing during this challenging time.

Submitting Claims to EDS May 23, 2007 Forward

DHHS and EDS are currently completing an assessment of the claims processing system to identify the business and technical changes that need to occur within DHHS' current NH Title XIX (Healthy Kids-Gold/Medicaid) claims processing system run by EDS to support the acceptance of a NPI for claims processing and payment.

During the contingency plan period it is extremely important that providers continue to include their NH Title XIX (Healthy Kids-Gold/Medicaid) Provider ID beyond the NPI effective date, May 23, 2007. DHHS and EDS will not be able to identify providers nor process and pay claims received on/or after May 23, 2007, unless the eight-digit NH Title XIX (Healthy Kids-Gold/Medicaid) Provider ID is included on all claims and other electronic transactions. Attached to this notice are the exact specifications of where to place the NH Provider ID on electronic claims. Also provided is information regarding where to place the NPI and taxonomy.

Please be sure that any changes made to paper claims software supports the continued capability of creating claims on the existing claim forms. Please do not switch to using the new claim forms until receiving further guidelines from EDS. It is imperative that the NH Title XIX (Healthy Kids-Gold/Medicaid) Provider ID continues to be included on all claims past May 23, 2007. Without it, EDS will not be able to identify the provider submitting the claim and the claim will be rejected.

NPI and Taxonomy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all providers who submit electronic claims for medical services must apply for a National Provider Identifier through the national enumerator. The intent of the NPI is to diminish the need for providers to maintain multiple different numbers to do business with different health plans. The NPI is a ten-digit number, whereas the current NH Title XIX (Healthy Kids-Gold/Medicaid) Provider ID number is an 8-digit number.

When applying for a NPI, providers must designate the taxonomy(ies) that best represents their provider type, classification, and area of specialization. Taxonomy is a 10-character alphanumeric code.

Future EDS claims processing and payment depends on being able to crosswalk a provider's new NPI(s) and taxonomy code(s) to the current NH Title XIX (Healthy Kids-Gold/Medicaid) Provider ID number(s). If, prior to requesting your NPI(s) and taxonomy(s) from the enumerator, you have questions regarding your taxonomy(s) selection and how it might affect your claims payment with EDS, we encourage you to contact EDS for a review of your particular situation.

Sharing your NPI and Taxonomy

All NH Title XIX (Healthy Kids-Gold/Medicaid) providers who have applied for or are in the process of applying for one or more NPI(s) are asked to provide EDS with their NPI(s) and corresponding taxonomy(ies) as soon as possible. Please forward both your NPI and taxonomy code, along with your NH Title XIX (Healthy Kids-Gold/Medicaid) Provider ID(s) that map to your NPI(s), on your office letterhead or provide a copy of your response letter from the enumerator. Please also include a contact name and phone number.

EDS' provider enrollment unit will be validating the information you provide, such as the address on the enumerator's response letter, your NPI(s), taxonomy selected and/or NH Title XIX provider number(s).

Please watch for future communication updates from EDS and DHHS on the NPI implementation status and what providers need to do to ensure uninterrupted processing of claims. Thank you for your patience and ongoing support of the program.

If you have any questions regarding this notice, please contact the EDS Provider Communications Unit at:
1-(800)- 423-8303 (NH & VT only) or (603) 224-1747.

Resources

For the latest information regarding NPI issues for health care providers, visit this web site:
http://www.cms.hhs.gov/NationalProvIdentStand

To obtain your NPI, visit this web site:
https://nppes.cms.hhs.gov/NPPES/Welcome.do

For a complete list of taxonomy codes, visit this web site:
http://www.wpc-edi.com/codes/taxonomy

ACCOMMODATING PATIENTS WITH DISABILITIES

Please note that free training resources are available to health care professionals regarding best practices for the treatment of patients with disabilities. The objectives of the training are to improve awareness of the abilities of, and effective methods of communicating with, people with disabilities, and to improve the knowledge of the Americans with Disabilities Act (ADA) and how it relates to accommodating patients who are disabled.

Training is available in the form of a workshop, or as a self-training via a CD-Rom. For more information, or to arrange for training, please contact:

Cheryl Killam, Accessibility Specialist
Governor's Commission on Disability
57 Regional Drive
Concord, NH 03301
1-800-852-3405 or 603-271-4177
cheryl.killam@NH.gov

PROVIDER IDENTIFICATION NUMBERS AND CONFIDENTIALITY
Please be reminded that your individual NH Medicaid provider number is specific to you, should be kept confidential, and should not be given out to anyone, especially not to your patients. Anyone in possession of your provider number may easily gain access to detailed information regarding claims, patient eligibility, and your financial transactions with NH Medicaid. Please call 1-800-432-8303 (NH/VT only) or (603) 224-1747 if you have questions regarding this article.

HOME HEALTH AND OTHER QUALIFIED AGENCIES

NEW DEFINITION OF ENTITIES THAT CAN PROVIDE AGENCY-DIRECTED PERSONAL CARE SERVICES
On August 17, 2006, the Joint Legislative Committee on Administrative Rules (JLCAR), approved the Bureau of Elderly and Adult Service's (BEAS) amendment to the rule, He-P 601, "Certification of Other Qualified Agencies". BEAS amended the definition of "agency-directed services" to be in compliance with RSA 151:2-b, IV. The former definition limited the provision of agency-directed personal care services to licensed home health agencies. The new definition states that both home health agencies and certified other qualified agencies can provide agency-directed personal care services to individuals eligible for the Home and Community Based Care for the Elderly and Chronically Ill (HCBC-ECI) Program. If you have questions regarding the contents of this article, please call Kim Hadank-Swinson, of the Bureau of Elderly and Adult Services, at (603) 271-7857.

HOSPITAL AND PHYSICIAN PROVIDERS

REPRINT OF STERILIZATION POLICY
This article is a reprint of the Department's sterilization policy, to point out to providers that this policy also applies to male sterilization, and that providers may receive reimbursement for vasectomies. Federal regulation, 42 CFR Part 50, requires that documentation of informed consent be obtained when medical procedures, funded by a federally assisted public health program, are performed that result in the sterilization of a recipient. Documentation of informed consent must include the signatures of the recipient, the person obtaining the consent, the interpreter if used, and the attending physician. **Please note: This sterilization policy also applies to vasectomies.**

All procedures that result in the sterilization of a recipient require documentation of informed consent. Informed consent is obtained from the recipient by using Form 112. This completed consent form must be attached to the claim form when submitting charges. A signed Form 112 must be obtained from all recipients undergoing a sterilization procedure.

The sterilization cannot be performed sooner than 30 days after the Form 112 is signed or later than 180 days after the date of signature on the Form 112. The only exceptions to this time frame are for Premature Delivery or Emergency Abdominal Surgery.

A copy of the Form 112 appears in the Appendix of this bulletin and may also be obtained in both English and Spanish, from the provider website at: www.nhmedicaid.com. Any claims for

sterilization procedure charges received by EDS that do not have a valid Form 112 attached will be denied.

Detailed billing guidelines for submitting claims related to sterilization procedures may be found in Section 2 of your provider-specific NH Title XIX Billing Manual.

If you have questions regarding the content of this article, please contact the Communications Unit at: 1-800-423-8303 (NH & VT only) or (603) 224-1717.

REMINDER- QIO HOSPITAL CLAIM RESUBMISSIONS

When the Northeast Health Care Quality Foundation, a Quality Improvement Organization (QIO), issues a Final Notice to a hospital as a result of a NH Medicaid inpatient review, EDS is instructed to recover the claim specified on the notice. The QIO may instruct hospitals to submit a new claim with corrected information as outlined in the notice. In this case, the new claim must follow the instructions given in the notice to avoid a second recoupment.

When submitting a new claim as a result of a QIO notice, you must use Condition Code C1 (Form Locators 24-30 on the UB92). Condition Code C1 is defined as: "Approved as Billed- The services provided for this billing period have been reviewed by the QIO/UR or intermediary."

If you have questions regarding the content of this article, please contact the Communications Unit at: 1-800-423-8303 (NH & VT only) or (603) 224-1717.

NURSING FACILITY, HEARING AND VISION SERVICES PROVIDERS

Hearing and Vision Services for Recipients in a Nursing Facility

NH Title XIX enrolled hearing service providers who provide services to Title XIX recipients who reside in a nursing facility may bill Medicaid **only** for the hearing aid devices. NH Title XIX enrolled vision services providers who provide services to Title XIX recipients who reside in a nursing facility may bill Medicaid **only** for the dispensing fee and for glasses and/or lenses. Other services related to the hearing aid, glasses or lenses are already included in the reimbursement rate of the nursing facility.

Examples of other services that are already included in the reimbursement rate of nursing facilities are ancillary services such as physical or occupational therapy, laboratory services, and radiological services. These services are included in the cost base, and are, therefore, already included in rates paid to the nursing facilities by NH Title XIX.

Please refer to the Nursing Home Provider Billing Manual for additional information, or call the Communications Unit at 1-800-423-8303 (NH/VT only), or (603) 224-1747 if you have any questions regarding this article.

PHYSICAL THERAPY PROVIDERS

Physical Therapy Services Provided by a Physical Therapy Assistant
The NH Title XIX program requires licensed physical therapists to be present during the provision of services when a physical therapy assistant is providing the services. Please refer to the Medical Assistance Rules, Chapter He-W 568.05 for further details. Rules pertaining to Medicaid may be found by going to the Department's website at www.dhhs.state.nh.us, and clicking on "Medicaid," then "Laws-Rules-Policies," and then "Medical Assistance, He-W 500." Scroll down until you find the rule for which you are searching.

NH Title XIX enrolled providers must adhere to the Medical Assistance Chapter Rules and their state licensing laws.

If you have questions regarding the content of this article, please contact the Communications Unit at: 1-800-423-8303 (NH & VT only) or (603) 224-1717.

OVERRIDE REQUEST

Provider Name: _____ Date: _____
(Please type or print)

Provider Number: _____

Recipient Name:	Identification Number	Amount of Claim:

INSTRUCTIONS:

1. Complete this form for each claim for which an override is being requested.
2. Enter the NH Medicaid Provider name, number and date of request in the spaces at the top of this form.
3. Enter the NH Medicaid Recipient's name, identification number, and the amount of the claim in the boxes provided at the top of this form.
4. Attach ONE CLEAN claim to this completed form for each request (please check type of claim being submitted): ☐ HCFA 1500 ☐ UB 92 ☐ Medicare Crossover ☐ TAD ☐ Dental

   In order to be accepted the claim:
   - must be legible,
   - must have the exact FDOS as initial claim billed,
   - must have like or corrected charges as initial claim billed.

5. If the claim was submitted previously, attach a copy of the Remittance Advice (please check all items that you have attached):

   ☐ NH Medicaid RA Dated _____ ☐ Official EDS Correspondence Dated _____ ☐ 8-digit batch # (if billed electronically) In this format: __ __ __C__ __ __ __ Dated _____

AN OVERRIDE REQUEST CAN NOT BE CONSIDERED FOR A PREVIOUSLY SUBMITTED CLAIM WITHOUT A COPY OF THE REMITTANCE ADVICE ATTACHED

- The RA must show the initial billing was less than 12 months from FDOS
- The attached claim corrects the previous reason(s) for denial
- All pertinent information must be circled on all RAs to pinpoint the facts and support the request: i.e., FDOS, RA dates, MID #s, Provider #s, Denial Codes

6. If the claim was **not** previously denied, but is over 12 months old, approval will be considered ONLY if (a) there was a delay in determining the NH Medicaid recipient's eligibility; (b) the claim is for a covered service provided during the retroactive eligibility period; and (c) the claim is submitted within six (6) months of the retroactive eligibility determination.

   Please indicate type of NH Medicaid Recipient eligibility:

   ☐ Regular NH Medicaid Eligibility ☐ Special Eligibility ☐ Nursing Facility

Send Completed Override Requests Plus Attachments to:
EDS
PO Box 2040
Concord, NH 03301-2040
Attn: One Year Override

FORM 112

Form Approved OMB
No. 0937-0166 Exp. date 12-95

CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

(CUT ALONG THIS LINE)

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ (Month Day Year)

I, _____, hereby consent of my own free will to be sterilized by _____ (doctor)

by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date: _____
Signature (Month Day Year)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter Date

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ (name of individual) signed the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ (Name: individual to be sterilized) on _____ (Date: sterilization operation)

I explained to him/her the nature of the sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery:

(describe circumstances):

_____
Physician

Date _____

1. Patient

GPO 930-465

NF

ATTACHMENT TO THE NPI NPI NOTICE

The following tables indicate the 837 transaction loops and segments where NH Medicaid Provider Identifiers and numbers, NPI and Taxonomy information, or your Medicare provider ID for crossover claims, are to be submitted for successful processing with NH Medicaid during our contingency period. The tables are broken out by claim types.

837I (Institutional)

X12N Loop Name	X12N Loop	Level
Billing/Pay-to Provider Hierarchical Level	2000A	Billing/Pay-to Provider Hierarchical Level
Billing Provider Name	2010AA	Billing/Pay-to Provider Hierarchical Level
Pay-to Provider Name	2010AB	Billing/Pay-to Provider Hierarchical Level
Attending Physician Name	2310A	Claim Level
Operating Physician Name	2310B	Claim Level
Other Provider Name	2310C	Claim Level
Attending Physician Name	2420A	Service Line Level (if different than claim level)
Operating Physician Name	2420B	Service Line Level (if different than claim level)
Other Provider Name	2420C	Service Line Level (if different than claim level)

In each of the loops indicated in the table above, the same "pattern" is used for reporting provider taxonomy, NPI, and other IDs. Specifically, the provider's taxonomy is always reported in a "PRV" segment, the provider's NPI is always reported in an "NM1" segment, and the provider's NH Medicaid or Medicare ID is always reported in a "REF" segment. In each case, the "qualifier" element indicates what kind of identifier is being reported in the "identifier" element. The following table indicates the usage of these segments as expected by the NH Medicaid.

X12N Loop	X12N Segment	X12N Element	NH Medicaid Usage
All provider information loops (see table above)	PRV	PRV02	'ZZ' to indicate PRV03 is a Taxonomy Code.
	PRV	PRV03	10-character Provider Taxonomy
	NM1	NM108	'XX' indicates that NM109 is an NPI.
	NM1	NM109	10-digit NPI
	REF	REF01	'1D' to indicate REF02 is a Medicaid ID, '1C' for Medicare ID.
	REF	REF02	8-digit NH Medicaid provider number or your Medicare ID

837P (Professional)

X12N Loop Name	X12N Loop	Level
Billing/Pay-to Provider Hierarchical Level	2000A	Billing/Pay-to Provider Hierarchical Level
Billing Provider Name	2010AA	Billing/Pay-to Provider Hierarchical Level
Pay-to Provider Name	2010AB	Billing/Pay-to Provider Hierarchical Level
Referring Provider Name	2310A	Claim Level
Rendering Provider Name	2310B	Claim Level
Purchased Service Provider Name	2310C	Claim Level (Doesn't use PRV Segment)
Service Facility Location	2310D	Claim Level (Doesn't use PRV Segment)
Supervising Provider Name	2310E	Claim Level (Doesn't use PRV Segment)
Other Payer Referring Provider	2330D	Claim Level (Doesn't use PRV Segment, NM1 not used for

X12N Loop Name	X12N Loop	Level
		NPI)
Other Payer Rendering Provider	2330E	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Other Payer Purchased Service Provider	2330F	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Other Payer Purchased Facility Location	2330G	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Other Payer Supervising Provider	2330H	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Rendering Provider Name	2420A	Service Line Level (if different than claim level)
Purchased Service Provider Name	2420B	Service Line Level (if different than claim level--Doesn't use PRV Segment)
Service Facility Location	2420C	Service Line Level (if different than claim level--Doesn't use PRV Segment)
Supervising Provider Name	2420D	Service Line Level (if different than claim level--Doesn't use PRV Segment)
Ordering Provider Name	2420E	Service Line Level (if different than claim level--Doesn't use PRV Segment)
Referring Provider Name	2420F	Service Line Level (if different than claim level)

In each of the loops indicated in the table above, the same "pattern" is used for reporting provider taxonomy, NPI and other ID's. Specifically, the provider's taxonomy is always reported in a "PRV" segment, the provider's NPI is always reported in an "NM1" segment, and the provider's NH Medicaid or Medicare ID is always reported in a "REF" segment. In each case, the "qualifier" element indicates what kind of identifier is being reported in the "identifier" element. The following table indicates the usage of these segments as expected by NH Medicaid.

X12N Loop	X12N Segment	X12N Element	NH Medicaid Usage
2000A, 2010AA, 2010AB, 2310A, 2310B, 2420A, 2420F	PRV	PRV02	'ZZ' to indicate PRV03 is a Taxonomy Code.
	PRV	PRV03	10-character Provider Taxonomy
2000A, 2010AA, 2010AB, 2310A, 2310B, 2310C, 2310D, 2310E, 2420A, 2420B, 2420C, 2420D, 2420E, 2420F	NM1	NM108	'XX' indicates that NM109 is an NPI.
	NM1	NM109	10-digit NPI
All provider information loops.	REF	REF01	'1D' to indicate REF02 is a Medicaid ID, '1C' for Medicare ID.
	REF	REF02	8-digit NH Medicaid provider number or your Medicare ID

837D (Dental)

X12N Loop Name	X12N Loop	Level
Billing/Pay-to Provider Hierarchical Level	2000A	Billing/Pay-to Provider Hierarchical Level
Billing Provider Name	2010AA	Billing/Pay-to Provider Hierarchical Level
Pay-to Provider Name	2010AB	Billing/Pay-to Provider Hierarchical Level
Referring Provider Name	2310A	Claim Level
Rendering Provider Name	2310B	Claim Level
Service Facility Location	2310C	Claim Level (Doesn't use PRV Segment)
Assistant Surgeon Name	2310D	Claim Level
Other Payer Referring Provider	2330D	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Other Payer Rendering Provider	2330E	Claim Level (Doesn't use PRV Segment, NM1 not used for NPI)
Rendering Provider Name	2420A	Service Line Level (if different than claim level)
Assistant Surgeon Name	2420C	Service Line Level (if different than claim level)

In each of the loops indicated in the table above, the same "pattern" is used for reporting provider taxonomy, NPI and other ID's. Specifically, the provider's taxonomy is always reported in a "PRV" segment, the provider's NPI is always reported in an "NM1" segment, and the provider's NH Medicaid or Medicare ID is always reported in a "REF" segment. In each case, the "qualifier" element indicates what kind of identifier is being reported in the "identifier" element. The following table indicates the usage of these segments as expected by the NH Medicaid.

X12N Loop	X12N Segment	X12N Element	NH Medicaid Usage
2000A, 2010AA, 2010AB, 2310A, 2310B, 2310D, 2420A, 2420C	PRV	PRV02	'ZZ' to indicate PRV03 is a Taxonomy Code.
	PRV	PRV03	10-character Provider Taxonomy
2000A, 2010AA, 2010AB, 2310A, 2310B, 2310C, 2310D, 2420A, 2420C	NM1	NM108	'XX' indicates that NM109 is an NPI.
	NM1	NM109	10-digit NPI
All provider information loops.	REF	REF01	'1D' to indicate REF02 is a Medicaid ID, '1C' for Medicare ID.
	REF	REF02	8-digit NH Medicaid provider number or your Medicare ID

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Provider Relations, EDS

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The goal of this publication is to provide current, accurate information relevant to providers of NH Medicaid. This publication is intended to complement the policy and billing information contained in the Provider Billing Manuals, Banner Pages, and Important Notices. We encourage input and feedback from you to assist us with this goal.

Please address inquiries and comments to the attention of your Provider Relations Representative at the address listed below:

EDS Provider Relations
PO Box 2040
Concord, NH 03301